EMPLOYER RESPONSE-QUIT:

NOTE: THIS INFORMATION WILL BE USED TO DETERMINE CLAIMANT'S ELIGIBILITY AND MAY ALSO AFFECT YOUR CHARGEABILITY RATE

Claimant Name:	SSN:
SALMON LOCAL OFFICE **IDAHO DEPARTMENT OF LABOR** **PO BOX 990** **SALMON ID 83467-0990** **208-756-4672 (FAX)**	Employer Name, Address, Phone & Fax

Paid or to be paid:		
Gross earnings for the past 12 months $	Severance: $	On (date):
Vacation: $	Bonus: $	On (date):
Date payment will be received:	Holiday: $	On (date):
Rate of Pay per hour: $	Pension or Retirement pay was paid or will be paid:	
Method of Interview: ☐ In Person ☐ By Telephone	$	On (date):
Supervisor's Name:	Employer's Phone#:	
Start Date of Employment:	Last Day Claimant Worked:	
Date Claimant informed you of the intent to quit:		

Please provide any documentation to support your position (ie: letter of resignation)

What reason (s) did the claimant give for quitting?
If the claimant cited work-related reasons, describe the working conditions:
What alternatives were available to the claimant? (leave of absence, transfer, grievance, etc.)
Describe any efforts the claimant made to resolve the problem and the outcome of those efforts:
If you do not agree with the claimant's statements, please state why:
Additional Information: Employer/Employer's Representative Signature: _____ Print Name: _____ Title: _____ Phone Number: _____ Date: _____ _____